Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT): AT-A-GLANCE

What is AF-CBT?

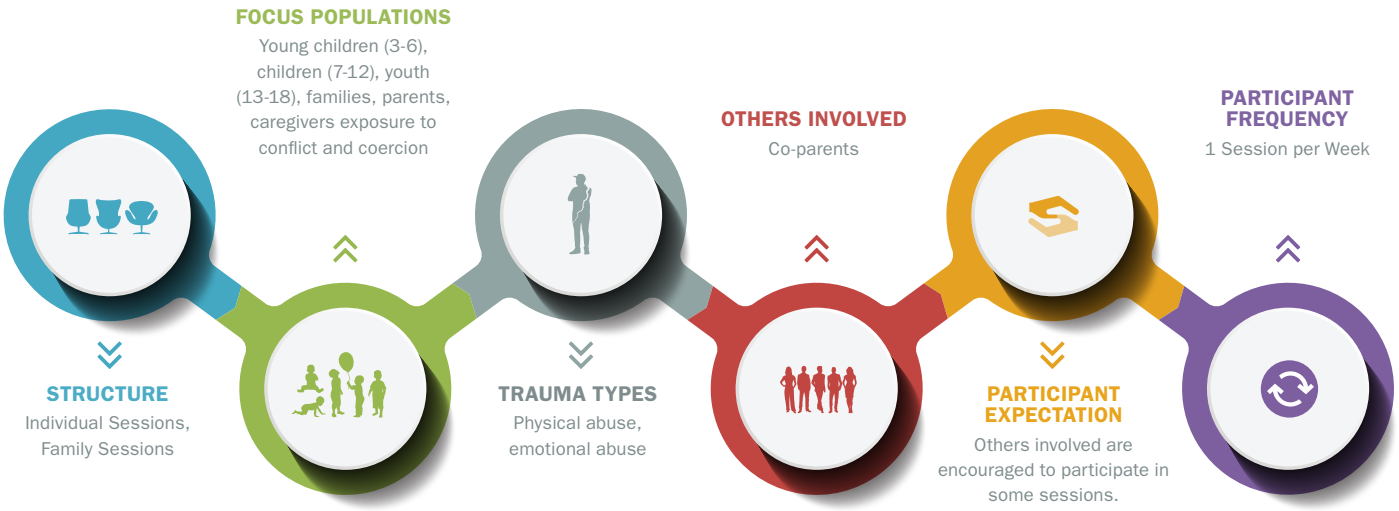
Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) is a comprehensive treatment approach for families with a child (5-17 yrs.) and any caregiver (e.g., regardless of biology, perpetrator status, or residence) who present with recent or a history of conflict and/or coercion. AF-CBT is a trauma-informed, evidence-based treatment (EBT) designed to improve the relationships between children and caregivers in families involved in anger/arguments (hostility, emotional abuse), physical force (corporal punishment, physical aggression), child physical abuse, or child behavior problems. Some children may experience Post-Traumatic Stress Disorder (PTSD) secondary to physical discipline/child physical abuse. AF–CBT seeks to reduce the clinical consequences of exposure to and strengthen protective factors to lower the risk for family conflict/coercion. AF–CBT teaches parents and children intrapersonal and interpersonal skills to enhance self-control, reduce aggressive behavior, and promote positive family relations (e.g., coping, anger management, cognitive restructuring, social skills, safe discipline strategies, imaginal exposure, healthy family problem solving, family clarification, communication).

What are the goals of AF-CBT?

In general, AF-CBT seeks to improve child behavior and well-being, help families interact and get along better, and maintain a safe and secure home environment. Its main goals are to achieve the following:

1. Support children and caregivers who are under stress and/or exposed to traumatic circumstances.
2. Improve child behavior and well-being.
3. Enhance child and family safety.
4. Strengthen family relationships and skills.
5. Reduce the risk for high conflict interactions.
6. Help caregiver and children to find effective ways to manage their emotions and be flexible in their thinking.
7. Promote effective use of discipline and feedback with children.

What does AF-CBT look like?



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Additional Information

Child and caregiver participate in alternating individual and then joint/family sessions. Session frequency is flexible and based on participant preferences. Families who show conflict, coercion, and/or physical abuse create substantial risk to children for development of significant difficulties such as aggression, poor interpersonal skills or functioning, and emotional reactivity. Caregivers in such families often report punitive or excessive parenting practices, frequent anger and hyperarousal, and negative child attributions, among other stressful practices. During the past few decades, research has documented the efficacy of several behavioral and cognitive-behavioral methods, many of which have been incorporated in AF-CBT.

What is the commitment?

Participate in intermittent sessions (not consecutive sessions) and practice skills outside of session. Session number varies (18-24 are common) duration can vary from 30-120 minutes, depending upon family preference. Your provider will tailor the material to your family's needs and set up a convenient schedule for you.

LOCATION:
Anywhere you and your provider decide

AF-CBT provides individual child, individual caregiver, and family sessions. Any adult caregiver (biological, foster, adoptive, etc.) can participate with at least one child. Now, some agencies see families in different settings, like a clinic, school, the home, or another community setting. Many families are seen once per week, but scheduling is highly flexible.

Families in AF-CBT can receive several services from one provider ("one stop shop"). This eliminates the need to see several different providers for parenting classes, anger management, family therapy, individual therapy, and trauma treatment. All of these services are bundled in AF-CBT.

Written assessment tools and interviews are used in assessment.

How do we know it works?

AF-CBT has practice-based evidence, research evidence, traditional knowledge, and case studies to support its benefits in hard-pressed child welfare and behavioral health treatment centers.

AF-CBT was developed by David Kolko in partnership with Elissa Brown, for families exposed to conflict and coercion. For more information, see page 3. Most children/youth/families involved in the initial development of this practice identified as African American, lived in an urban environment, and spoke English at home.

Additionally, there have been adaptations of the practice for foster families and other adaptations are under development (e.g., Working with Black/African-American families or Spanish-speaking families; working with substance using clients). There are translations of AF-CBT materials for children, youth, and families available in Spanish, Japanese, Hebrew, and Korean. Learn more on page 3.

For more information explore the next several pages or check out:

www.afcbt.org

AF-CBT: THE EVIDENCE

What types of evidence are available for AF-CBT?

- ❒ Evidence-based Treatment
- ❒ Practice-Based Evidence
- ❒ Case Study
- ❒ Quasi-experimental Research
- ❒ Randomized Clinical/Controlled Trial

Where can I learn more about the evidence?

- Alternatives for Families: A CBT website
- Effectiveness of AF-CBT
- Clinical monitoring of AF-CBT
- Implementation of AF-CBT
- Evidence based clearinghouse - review of AF-CBT
- Sustainabililty of AF-CBT
- Comparison of CBT and Family therapy
- Comparison of online vs. in person training in AF-CBT
- Overview and Case Example of AF-CBT

How is AF-CBT measured in real time?

Providers use the Weekly Safety Check-in (WSCI) and Topic Tracker to monitor treatment progress. As described on our website, four brief assessments capture outcome targets: Alabama Parenting Questionnaire-Short Form with 3 original corporal punishment items (APQ-SF; Elgar et al., 2007); Brief Child Abuse Potential Inventory (Ondersma et al., 2008); Child Posttraumatic Stress Scale (CPSS; Foa et al., 2017), and Strengths and Difficulties Questionnaire (Bourdon et al. 2005).

> ***I can think of families where AFCBT has been a life changer for them. This model led to an amazing transformation, from helplessness to being a strong, healthy family. I have just seen it work miracles and wish more families could do it.***
>
> – Program Director

What changes for the better as a result of AF-CBT?

AF-CBT helps children, caregivers, and families learn safe and more effective ways to overcome or prevent these struggles. That's why AF-CBT delivers specialized content and skills in three phases: 1) Engagement and Psychoeducation (e.g., learning about family experiences), 2) Individual Skill-building (e.g., emotion regulation, noticing positive behavior), and 3) Family Applications (e.g., communication, problem solving). For more on scientific support, click Resource tab and then Evidence and Research folder, on our website.

What do the numbers tell us (i.e., quantitative data)?

Our data from prior studies show improved caregiver-child relationships, healthy parenting practices, enhanced children's coping and social skills, reduced behavioral problems in children, healthier reactions to stressful or traumatic situations, and feeling safer and secure at home. We have also shown reduced verbal/physical aggression and family conflict, and greater parenting nurturing.

What do the stories tell us (i.e., qualitative data)?

Besides the gains on clinical measures, we see a notable change in the relationships between caregivers and children, as they communicate more clearly and with less conflict and kindness. Participants report an appreciation for incorporating their values/preferences into treatment decisions, use of in session progress monitoring tools, and the balance in child and caregiver content/sessions.

AF-CBT: ADAPTABILITY AND ACCESSIBILITY

- **What is the history of AF-CBT?**

  The initial edition (Ed.1) was developed in 1985 by David J. Kolko in collaboration with Sharon (Fishman) Hicks (see Kolko 1996a, 1996b; Kolko et al., 2011). Next, this content was updated for a sourcebook co-written with Cynthia C. Swenson, Ph.D. (Kolko & Swenson, 2002) which included several foundational topics and materials. This material was expanded and later described as Abuse-Focused Cognitive-Behavioral Therapy in an early compendium of interventions (Kolko 2003a, 2003b). AF-CBT was then adapted (Ed.2) and the name changed to Alternatives for Families: A Cognitive-Behavior Therapy in 2007 by David J. Kolko, Amy D. Herschell, Barbara L. Baumann, and Meghan Shaver (see Kolko et al., 2012, 2018) to better reflect its focus on skills training methods and minimize potential stigma. A related model (PARTNERS CBT for Physical Abuse) was developed by Elissa J. Brown in 2002 (see NCCAN, SAMHSA). In 2010, these two related approaches were integrated into the current edition (Ed.3).

- **How did AF-CBT developers proactively reach out to, center, amplify, and learn from the voices of those most impacted by racism and trauma?**

  We have used community and parent advisory groups, stakeholder panels, and focus groups that include community members from various racial/ethnic/religious backgrounds to provide feedback on the model and its delivery. We also routinely obtain feedback from trainees/providers and families who attend our clinics to help us revise our training and treatment methods.

- **What is the role of AF-CBT providers in tailoring the model for individuals, families, and communities?**

  Clinicians tailor the session guide material to the needs of the clients, so it requires clinician decision-making about what content should be emphasized. They also determine the length of care, how to integrate difficult to engage families, and how best to draw upon their considerable personal and professional resources. The session guide includes comprehensive content and handouts.

- **How are lessons learned from individuals, families, communities and providers used to keep improving AF-CBT?**

  We incorporate feedback from implementation advisory groups, provider groups, and families in supervision and training. We also collect formal and informal feedback during trainings and after consultation ends (see Baumann et al., 2023; Kolko et al., 2012). The gains and challenges reported by caregivers and children are routinely used to support changes in our procedures and content.

- **Resources and materials are available:**

  - AF-CBT session guide (manual) is available in English, Spanish, and Japanese. Handouts are available in these languages as well as in Korean and Hebrew. Translations were made by native language speakers (trained providers) and back translated.
  - Materials are available in written, video, and audio formats. Some of our newer videos have closed captioning. There are captions available for video materials. We have diverse providers and family case histories.
  - A web-based course that will provide an asynchronous professional skills training in the use of AF-CBT is in the final stages of development and should be available by 2026.
  - For more information on adaptation and access, please visit our website (www.afcbt.org), which has general information and tabs for different audiences.

AF-CBT: PROVIDING, SUPERVISING, TRAINING, AND SUSTAINING

TO PROVIDE AF-CBT

Provider prerequisites:

- Experience: None
- Education: Master's degree
- Licensure: Licensed or working under licensed supervisor

Trained providers can:

- Deliver AF-CBT
- Apply for/earn certification in AF-CBT
- Qualify for enhanced rates if available

Access for Provider Training (using a Learning Community that includes all of these components):

- Through a professional skills training (i.e., live in-person training, a live virtual training, or a self-paced/web-based training course)
- Through monthly consultation calls to support implementation
- Through a session guide

TO SUPERVISE AF-CBT

Supervisor prerequisites:

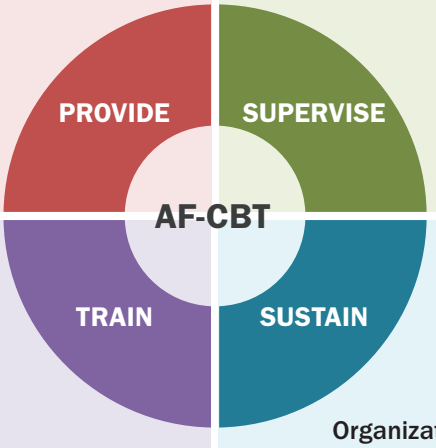
- There is no requirement for providing supervision in the model. We suggest that supervisors meet the same provider prerequisites and simply take the same provider training

Trained supervisors can:

- n/a

Access for Supervisor Training:

- We offer no specific supervisor training, but can address supervisor inquiries via our online Q&A form.



TO TRAIN AF-CBT

Trainer prerequisites:

- Meet Provider prerequisites
- Be a certified clinician and submit application
- Submit/complete train-the-trainer process

Approved trainers can:

- Train within their own organization
- Train locally
- Train providers
- Be listed on the trainer list.

Access for Trainer Training:

- Through live in-person training
- Through pre-recorded training
- Through consultation

TO SUSTAIN AF-CBT

Organization prerequisites:

- Internal discussions on readiness and fit
- Support a training infrastructure
- Commit to regular meetings dedicated to sustaining the practice

Organizations can:

- Market certified providers and trainers
- Train new staff on the job by in-agency trainers
- Can receive agency or individual trainings

Access for Organizational Readiness Supports:

- Virtual/hybrid/in-person continuing education
- Assessment resources/supports as part of training cost
- Refer to the Community Change Framework for guidance

AF-CBT: MORE ON PROVIDING, SUPERVISING, TRAINING, AND SUSTAINING

PROVIDE AF-CBT

- **Training cost:** $1250
- **Time Commitment:** 13 months - participate in an AF-CBT Learning Community
- **Additional Details:** See training and certification page on website (www.afcbt.org)

SUPERVISE AF-CBT

- **Training cost:** non-applicable - just take the provider training.
- **Time Commitment:** We do provide ongoing calls with supervisors for those who are interested, during a routine Learning Community.
- **Additional Details:** Supervisors are strongly encouraged to apply to learn AF-CBT with the support of their employing agency. This is desirable, as we know how important supervisor expertise/support can be.

TRAIN AF-CBT

- **Training cost:** $1,500 ($750 provided on application and $750 at end of certification process).
- **Time Commitment:** 10 hours remote 1:1 training, 16 h workshop delivery with experienced trainer, 16 hours of training delivery (while being observed by faculty), and 16 hrs delivery on their own.
- **Additional Details:** There is a detailed curriculum for the in-house trainer program. All in-house trainers are provided online access to current training and clinical materials

SUSTAIN AF-CBT

- **Training cost:** Our provider training program (noted above) addresses implementation and sustainment plans.
- **Time Commitment:** 13 months per learning community
- **Additional Details:** See website for AF-CBT Community Change Framework learning for agency expectations and use Q&A portal to request any materials.

To learn more about providing, supervising, training, or sustaining, please see www.afcbt.org.

For additional resources and related products, please explore: www.afcbt.org.

This Alternatives for Families: A Cognitive Behavioral Therapy (AF-CBT) At-A-Glance was reviewed and approved for accuracy in October, 2025 by David J. Kolko Ph.D., and Elissa J. Brown, Ph.D., (co-developers) , Barbara L. Baumann, Ph.D., (national trainer and consultant) and Kevin Rumbarger, BA (Administrative Coordinator); Drs. Kolko and Baumann are at the U. of Pittsburgh School of Medicine, and Dr. Brown is with St. John University.

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